

**CENTER FOR INTEGRATIVE MEDICINE**

REGISTRATION FORM

**(PLEASE "PRINT")**

Today's Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**PATIENT INFORMATION:**

First Name: \_\_\_\_\_ MI \_\_\_\_\_ Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Primary phone #: \_\_\_\_\_ / \_\_\_\_\_ Cell or secondary phone #: \_\_\_\_\_ / \_\_\_\_\_

Email Address: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX (M/F) \_\_\_\_\_ MARITAL STATUS: S M D W

SSN #: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Phone: \_\_\_\_\_ / \_\_\_\_\_

\*Other family members seen here: \_\_\_\_\_

**INSURANCE INFORMATION: \*\* WE NEED A COPY OF YOUR CURRENT INSURANCE CARD ! \*\***

Person responsible for bill: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Is this person a patient here?  Yes  No Phone #: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Name of Primary Insurance: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ SSN#: \_\_\_\_\_

Subscriber's Birth date: \_\_\_\_\_ Patient's relationship to subscriber: self child spouse other

Name of Secondary Insurance (if applicable): \_\_\_\_\_

Subscriber's name: \_\_\_\_\_

SSN#: \_\_\_\_\_

Subscriber's Birth date: \_\_\_\_\_ Patient's relationship to subscriber: self child spouse other

**EMERGENCY CONTACT PERSON (OTHER THAN SPOUSE):** \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_ / \_\_\_\_\_ CELL: \_\_\_\_\_ / \_\_\_\_\_

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I, THE UNDERSIGNED, GIVE AUTHORIZATION TO TREAT AND ASSIGN DIRECTLY TO THE CENTER FOR INTEGRATIVE MEDICINE, ALL MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS AND AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

CENTER FOR INTEGRATIVE MEDICINE

**CLINICAL TESTING NOTIFICATION CONSENT**

We are thankful to be a partner with you in your healthcare. To keep you informed about your health, we will notify you about the results of clinical testing. Please tell us how you would like to be contacted by ***initialing*** the appropriate response:

\_\_\_\_\_ Please call me at this number \_\_\_\_\_ or \_\_\_\_\_

If I am not available at one of the numbers listed above, I authorize you to leave a message on my answering machine (and/or voice mail)

Yes

No

OR

I authorize you to leave a message with my spouse or family member

Yes

No

\_\_\_\_\_ Please mail my results to:

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We will make 3 attempts to contact you. If we cannot reach you by phone, we will mail you the results at the mailing address you provided in your medical chart.

I understand that it is my responsibility to notify the Center for Integrative Medicine ***in writing*** if this information changes.

Patient Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

**Notifications and Releases**

We want to make your experience with every aspect of our service, meet or exceed your expectations. If you have any questions or concerns, suggestions for improvement in our services, or any comments, please do not hesitate to speak with any of our staff or physicians.

Listed below are several notices that outline certain responsibilities of ours, and yours. **Please read them carefully and sign where indicated that you have read each statement.**

**\*\*General Consent for Treatment**

We look forward to treating you as a patient, however, we need your permission for our physicians to examine you, provide treatments, and perform diagnostic studies as necessary. If more invasive procedures are deemed necessary, the risks and benefits of those invasive treatments will be explained to you. When you agree to proceed with an invasive treatment, you will be asked to sign a more detailed consent.

**I give general consent to be treated.**

Date: \_\_\_\_\_

**Patient / Patient's representative**

**\*\*Financial Policy / Assignment of Benefits**

As a courtesy to our patients, the practice accepts assignment from most commercial insurance programs. We will file your primary insurance claim for you. Once the primary insurance has paid, we will also file your secondary insurance, if you have provided us with that information. However, insurance is a contract between you and your insurance company. Therefore, we ask that you acknowledge your responsibility for the payment of our services.

**A 24-hour notification is required for cancelled/rescheduled appointments, or you will be subject to a fee.** \_\_\_\_\_ (patient initial)

If the insurance denies coverage, disallows a service, or otherwise does not pay the claim, you are still responsible for the fees. Balances not paid within 30 days after your first treatment will be subject to a 1½% service charge per month. In addition, if the fees for our services are not paid, we may turn the account to a collection agency. Attorney's fees and court costs will also be added to the outstanding balance if it becomes necessary to take legal action to collect past due amounts. Also, your insurance company may ask us to provide information concerning your treatment before they will pay for the services.

**I acknowledge it is my responsibility to ensure payment of fees for services provided by the practice and authorize the practice to release any medical information, if necessary, to my insurance company.**

Date: \_\_\_\_\_

\_\_\_\_\_  
Patient / Patient's representative

**\*\*Privacy Policy**

New federal regulations require physician practices to keep your medical information private. Our practice has always guarded the privacy of our patients. We only share medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues. We will keep your record as long as you are a patient of the practice and seven years after your last visit.

**I acknowledge that I have been informed about the privacy of my medical record, and the practice's Privacy Policy has been made available to me.**

Date: \_\_\_\_\_

\_\_\_\_\_  
Patient

## PRIVACY RESTRICTION

As your healthcare provider, I want you to understand that everything you tell me is confidential. New federal regulations require physician practices to keep your medical information private. Our practice has always guarded the privacy of our patients. We only share your medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues. We will not discuss your condition with anyone else (i.e., parents/guardians, spouses) without your approval in writing.

**I understand the above statement and (check one box below):**

- ( ) I do not mind that my medical information is shared with my parent/guardian or spouse at anytime.
- ( ) I want my medical information to remain confidential. My protected health information should *NOT* be shared with any other individual. I realize that unless I pay cash for all services provided, there is a chance that an insurance company may release information to the person(s) paying for my medical insurance. I also realize that this restriction must be approved by Center for Integrative Medicine Privacy Officer, who may deny my request.

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Patient Signature

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Date

**Emergency Treatment EXCEPTION:** If the Privacy Office agrees to a restriction, HIPAA privacy regulations provide an exception in emergency treatment situations for a hospital or physician to use and disclose necessary information to treat the patient.

Created on 03/25/03



Please describe the major health concern that you wish to address in this visit.

Health Concerns	Provider's Comments

Have you seen any other providers for this health concern?  Yes  No

Please list any other significant concerns that you currently have:


Please list any surgeries, hospitalizations or major illness you have had. Please note the approximate dates of these events.


Please list all medications which you currently take. Include non-prescription medications such as Tylenol.

Medication	Dose	Frequency	Prescribed By	Provider Notes

Please list all supplements, vitamins, and herbal products.

Supplement, etc.	Dose	Frequency	Prescribed By	Provider Notes

Do you have any allergies to food or medications?  Yes  No If yes, please list below:

Medication or Food:	Reaction:

## Personal Health History

Have you been diagnosed with any of the following illnesses?

Illness	Yes	No	Year	Provider Notes
Anemia				
Asthma				
Blood clots				
High blood pressure				
High cholesterol				
Cancer				
Chronic fatigue syndrome				
Gestational Diabetes				
Diabetes				
Endometriosis				
Fibromyalgia				
Glaucoma				
Hepatitis				
Heart disease				
HIV/AIDS				
Kidney stones				
Migraine				
Thyroid disease				
Seizures				
Sleep apnea				
STD's				
Stroke				
Others:				

**Personal Health History:**

Have you had:	No	Yes	If yes, when? Month/Year	Provider's Comments
Blood pressure check			/	
Urinalysis			/	
Glaucoma Screening			/	
Eye exam			/	
Chest X-ray			/	
Cholesterol test			/	
Stress Test (for heart)			/	
Test of stool for blood (Stool Guaiac Test)			/	
Colonoscopy			/	
Flexible sigmoidoscopy			/	
Rectal exam to examine prostate (males)			/	
PSA blood test for prostate (males)			/	
Mammogram (females)			/	
Pap/pelvic exam (females)			/	
Bone Density Test (females)			/	

**Which immunizations have you had?**

Immunizations	No	Yes	If yes, when? Month/Year	Provider's Comments
Tetanus			/	
Flu Vaccine			/	
Pneumonia vaccine			/	
Hepatitis A			/	
Hepatitis B			/	
MMR			/	
Chicken Pox			/	

**Family History**

Family History	If Living, Age?		If deceased, cause and age of death?	Provider's Notes
Father:				
Mother:				
Paternal grandfather				
Paternal grandmother				
Maternal grandfather				
Maternal grandmother				
Siblings:				
Have any of your relatives had the following?	No	Yes	If yes, which relative?	Age of time of diagnosis?
Heart disease (Heart attack, heart surgery, etc)				
Stroke				
High Blood Pressure				
High cholesterol				
Diabetes				
Thyroid Disease				
Breast Cancer				
Other Cancer(s)				
Depression				
Mental Health disorder				
Suicide				
Osteoporosis				
Alcoholism				
Drug Abuse				
Migraines				

**Pain Assessment:**

- 1. Where does it hurt? \_\_\_\_\_
- 2. How long does the pain last? \_\_\_\_\_
- 3. What makes the pain worse? \_\_\_\_\_
- 4. What makes it better? \_\_\_\_\_

5. Describe the quality of your pain (Circle all that applies.) Burning Throbbing  
Spasm Piercing Sharp Dull Heavy Stabbing  
Nagging Steady Intermittent Other \_\_\_\_\_

6. Using the pain scale of 1-10, with zero meaning no pain and 10 meaning worst pain, what level is your pain now?

Least pain    very mild    mild    moderate severe    worst pain  
0 1 2 3 4 5 6 7 8 9 10

what level is your pain usually?

Least pain    very mild    mild    moderate severe    worst pain  
0 1 2 3 4 5 6 7 8 9 10

7. When did this pain begin? \_\_\_\_\_

8. Does it vary? \_\_\_\_\_ How? \_\_\_\_\_

9. What level of pain can you tolerate with activity of daily living?

Least pain    very mild    mild    moderate severe    worst pain  
0 1 2 3 4 5 6 7 8 9 10

10. Does your pain interfere with your activity?

Daily Living?

Yes     No     Sometimes \_\_\_\_\_

Emotions?

Yes     No     Sometimes \_\_\_\_\_

Family?

Yes     No     Sometimes \_\_\_\_\_

Work?

Yes     No     Sometimes \_\_\_\_\_

Sexuality?

Yes     No     Sometimes \_\_\_\_\_

Relaxation?

Yes     No     Sometimes \_\_\_\_\_

## Lifestyle Habits

- Do you routinely wear a seat belt?  Yes  No
- Do you have any pets?  Yes  No
- Are you sexually active?  Yes  No
- Are you sexually active with  men  women or  both?

How many sexual partners have you had in the past year? \_\_\_\_\_

Are you using a form of contraception?  Yes  No  N/A

Have you ever had a sexually transmitted disease?  Yes  No

Have you ever had a blood transfusion?  Yes  No

Have you ever used intravenous drugs?  Yes  No

## Exercise

Consider your physical activity during the last month and check the box next to the statement that best describes your exercise habits:

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### How often do you exercise

- Daily or almost daily
- 3 - 5 times a week
- 1 - 2 times a week
- A few times a month
- Less than once a month

### How long do you exercise?

- Over 45 minutes per session
- 30-45 minutes per session
- 20-30 minutes per session
- 10-20 minutes per session
- Less than 10 minutes per session

### What types of activities do you perform?

- Walking
- Running
- Swimming
- Housework/Yard Work
- Flexibility exercises
- Strength Training
- Sports
- Yoga
- Cycling
- Hiking
- Other

## Nutrition

Please describe your typical diet:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Are there any foods that you avoid? \_\_\_\_\_

Do you follow any certain diet plan? If yes, please note what type. \_\_\_\_\_

How many fruits and vegetables (1/2 cup serving size) do you usually eat daily?

1-2    3-4    5-6    >7 .

How many servings of whole grains (1/2 cup serving size) do you eat daily?

1-3    4-6    7-9    >10

How many glasses of water (8 oz serving size) do you drink daily?

1-3    4-6    7-9    >10

How many servings of meat (3 oz. serving size) do you eat daily?

0    1-2    3-4    5-6    >7

How many soft drinks (12 oz. serving size) do you drink daily?

0    1-3    4-6    >7

How many servings of caffeine do you drink daily?

\_\_\_\_\_ coffee    \_\_\_\_\_ soda    \_\_\_\_\_ tea

**How many alcoholic drinks do you drink weekly?** (serving size: 12 oz beer, 5 oz wine, 1/2 oz liquor)

0    <1/mo    <1/wk    1-4/wk    5-8/wk    >8/wk

If you drink alcohol, please answer the following questions:

1. Have you ever felt you should cut down on your drinking?     Yes     No
2. Have people annoyed you by criticizing your drinking?     Yes     No
3. Have you ever felt bad or guilty by your drinking?     Yes     No
4. Have you ever had a drink first thing in the morning to get rid of a hangover?     Yes     No

## Tobacco Use

Do you now, or have you in the past, used tobacco products? (Circle One)

Never

In past    When did you quit? \_\_\_\_\_  
              How much did you smoke? \_\_\_\_\_  
              How long did you smoke? \_\_\_\_\_

Current    How much do you smoke? \_\_\_\_\_  
              How long have you smoked? \_\_\_\_\_

Have you every tried to quit?         Yes    No

Number of attempts to quit? \_\_\_\_\_

What method have you used to quit? \_\_\_\_\_

Do you desire to quit?         Yes    No

Do you now, or have you in the past, used recreational drugs?         Yes  No

If yes, then what have you used? \_\_\_\_\_

How long? \_\_\_\_\_

How often? \_\_\_\_\_

## Depression

Circle the statements that you easily answer "yes" to.

1. I am unable to do the things I used to do.
2. I feel hopeless about the future.
3. I can't make decisions.
4. I feel sluggish or restless.
5. I am gaining or losing weight.
6. I get tired for no reason.
7. I am sleeping too much, or too little.
8. I feel unhappy.
9. I become irritable or anxious.
10. I think about dying or killing myself.

## Sleep

How many hours per night are you sleeping? \_\_\_\_\_

Do you have trouble falling asleep or waking up in the night? (Circle One)

How often? \_\_\_\_\_

Do you wake up feeling refreshed?    Yes    No

Do you snore or hold your breath while sleeping?  Yes    No

Do you have trouble staying awake while sitting quiet?    Yes    No

**Stress Management**

On a scale from 1-10, with 10 being the worse stress, what is your normal everyday stress level? Circle one.

0      1-2                  3-4                  5-6                  7-8                  9-10

Where does most of your stress come from? \_\_\_\_\_

How do you manage your stress? \_\_\_\_\_

How does stress affect you? \_\_\_\_\_

Do you have a spiritual framework? \_\_\_\_\_

What brings you the greatest joy? \_\_\_\_\_

What things in life create the greatest challenges for you? \_\_\_\_\_

What is your greatest fear? \_\_\_\_\_

What are your overall goals in terms of your health and lifestyle for the present and for the next 5 years? \_\_\_\_\_

\_\_\_\_\_

What would success look like from this encounter? \_\_\_\_\_

\_\_\_\_\_

**Clinician Comments on History**

**Symptom Review: Circle the symptoms that you are experiencing.**

**General**

Weight change  
Fever Fatigue  
Chills  
Night sweats  
Appetite change  
Sleep problems

**Skin**

Itching  
Rash  
Mole change  
Hair change  
Color change  
Non-healing sores

**Eyes**

Vision change  
Double vision  
Pain  
Spots / Floaters  
Itching  
Watering  
Redness

**Ears**

Ear pain  
Hearing loss  
Use of hearing aid  
Ringing in ears

**Nose**

Nose bleeds  
Congestion  
Runny nose  
Itching  
Sinus problems

**Mouth, Throat**

Teeth problems  
Mouth sores  
Sore throat  
Difficulty swallowing  
Hoarseness

**Neck**

Lump  
Swollen glands  
Pain

**Breasts**

Lump  
Pain  
Nipple discharge

**Lungs**

Cough  
Wheeze  
Shortness of breath  
Sputum  
Coughing up blood

**Heart/Vessels**

Chest pain  
Swelling feet/legs  
Palpitations  
Murmur  
Calf pain with walking  
Varicose veins  
Easy bruising / bleeding

**Stomach**

Heartburn  
Nausea / Vomiting  
Diarrhea  
Constipation  
Bowel changes  
Bloody stools  
Black stools  
Abdominal pain  
Excessive gas/belching  
Hemorrhoids

**Urinary**

Burning  
Frequent urination  
Painful urination  
Blood in urine  
Reduced urine flow  
Hesitancy  
Dribbling  
Wake up to urinate  
Incontinence

**Muscle/Skeleton**

see pain assessment  
Joint pain  
Joint swelling  
Joint redness  
Neck pain  
Back pain  
Muscle pain

**Neurological**

Paralysis  
Seizures  
Fainting  
Muscle weakness  
Balance problems  
Coordination problems  
Numbness  
Tremors  
Memory changes  
Headache

**Female Reproductive**

Abnormal vaginal bleeding  
Vaginal discharge  
Vaginal dryness  
Vaginal itching  
Painful intercourse  
Painful periods  
PMS  
Hot flashes / Night sweats  
Problems with sex  
Genital sores  
(G: \_\_ P: \_\_ AB: \_\_ SAB: \_\_  
LC: \_\_)

**Male Reproductive**

Discharge from penis  
Sores on penis  
Testicular pain  
Testicular lump  
Problems with sex  
Erection problems  
Prostate problems

**Emotional**

Depression  
Loss of sleep  
Nervousness  
Anxiety  
Stress  
Trouble concentrating